Washington State Department of Social & Health Services

Documentation Request for Medical/Disability Condition

Dear Health Care Provider:

_____ (name of client) has told us that a medical condition prevents or limits participation in WorkFirst activities that could include job search, job preparation, education classes, training, or working.

Please complete the enclosed form to describe these limitations.

We will use this information to determine the level of participation up to 40 hours per week, in job search, job preparation, educational classes, training, or working.

Please kindly provide us with information by _____ (deadline date). If we do not receive any information from you, we may require full-time participation, up to 40 hours per week, in the types of activities described above.

If you have any questions or need more time to send us the information, please call me at _____ (number of worker).

Thank you,

_____

Worker's Name

Washington State Department of Social & Health Services

WORKFIRST

Documentation Request for Medical/Disability Condition

CLIENT NAME	CLIENT IDENTIFICATION NUMBER
WORKFIRST STAFF NAME	TELEPHONE NUMBER
COMMUNITY SERVICES OFFICE (CSO) ADDRESS	

To help the department determine the limitation(s) of the above-named individual, please provide the following information:

1. Does this person have specific physical, mental, emotional, or developmental issues that require special accommodations or considerations? ☐ Yes ☐ No If yes, type of condition(s) or diagnosis:

   Is this supported by any testing, lab reports, etc.? ☐ Yes ☐ No If yes, attach and send documents.

2. Does the condition(s) limit the person's ability to work(e.g., lift heavy objects, stand or sit for long periods of time, follow instructions, bend over, reach above, concentrate for extended periods of time, repetitive motions, interact with people, and/or exposure to chemicals, synthetic materials, etc.)? ☐ Yes ☐ No

   If yes, describe any specific limitations:

   If yes, this person should be limited to the following times limits per week:
   ☐ 0 hrs (unable to participate) ☐ 1 – 10 hrs ☐ 11 – 20 hrs ☐ 21 – 30 hrs ☐ 31 – 40 hrs.

3. Does the condition(s) limit the person's ability to participate in activities related to preparing for and looking for work (e.g. attend educational or vocational classes which may involve sitting for extended periods of time, complete job applications which may involve memory retention, reading/writing, and information gathering, make and keep appointments, use transportation, stand in line, participate in interviews, follow a written employability plan, and/or advocate for him/herself? ☐ Yes ☐ No

   If yes, describe how:

   If yes, this person should be limited to the following times limits per week:
   ☐ 0 hrs (unable to participate) ☐ 1 – 10 hrs ☐ 11 – 20 hrs ☐ 21 – 30 hrs ☐ 31 – 40 hrs.

4. Does this person have any limitations with lifting and carrying? ☐ Yes ☐ No

   If yes, this person has the following limitations:

   ☐ Sedentary work: Up to five (5) pounds frequently with occasional carrying of up to 10 pounds maximum.

   ☐ Light work: Up to ten pounds frequently with occasional carrying of up to 20 pounds maximum.

   ☐ Medium work: Up to 25 pounds frequently with occasional carrying of up to 50 pounds maximum.

5. Does this person's condition(s) impact his/her ability to access services (e.g., use the telephone, receive treatment, make and keep appointments, use transportation services, find locations of services)? ☐ Yes ☐ No

   If yes, describe:

6. How long will the person's condition likely limit the ability to work, looking for work, or train to work?

   _____ Weeks _____ Months _____ This is a permanent condition.

7. Is there a specific treatment plan that you made to address this person's health-related condition or disability? ☐ Yes ☐ No

   If yes, describe the treatment plan.

8. Are there specific issues that need further evaluation or assessment? ☐ Yes ☐ No

   If yes, please describe what type of assessment or evaluation and to what type of specialist this person should be referred.

MEDICAL/MENTAL HEALTH CARE PROVIDER/OTHER PROFESSIONAL

SIGNATURE	DATE	TELEPHONE NUMBER

PRINTED NAME

MAILING ADDRESS	CITY	STATE	ZIP CODE
		WA	

AUTHORIZATION TO RELEASE INFORMATION

I authorize _____ to release to the Department of Social and Health Services the information on this form and any medical record information that substantiates the illness/injury condition that prevents me from working, solely to evaluate my capacity to participate in the WorkFirst Program. I understand that this release specifically includes diagnostic testing or treatment information concerning mental health, alcohol or drug abuse and the result of Sexually Transmitted Diseases (STD), including HIV/AIDS, when such information is part of the record. (Revised Code of Washington (RCW) 78.24.105)

PATIENT'S SIGNATURE	DATE

INSTRUCTIONS

DSHS WorkFirst Case Manager/Social Worker: The purpose of this form is to assist you in developing an Individual Responsibility Plan when, as a result of a condition or disability, there is an impact on the person's ability to work, look for work, attend training and/or access services. **Use of this form is NOT mandatory if other documentation exists.** You may give this form to the applicant/recipient to take to the appropriate professional service provider for completion or you may mail this directly to the provider. If you choose to mail this form, enclose a self-addressed metered envelope including your name to ensure the form will be returned to the appropriate person.

DSHS Customer: The purpose of this form is to gather information from a medical provider that will assist your Case Manager or Social Worker in reviewing your health issues and creating an Individual Responsibility Plan that best fits your specific needs and limitations.

Physician/Health Care Provider: For adult clients to get public assistance (TANF), they are required to work, actively look for work, or get training to work for 32 to 40 hours per week. Some clients may not be able to meet this requirement because of health-related issues. These clients may need to be temporarily deferred from a work activity, may be able to participate but for a limited number of hours, or may need to avoid certain types of work activities. Please complete this form and give to client or send to the WorkFirst Case Manager or Social Worker, using the enclosed envelope OR send us any notes, letters or other documentation you already have in your records that address the person's limitations.